the laboratory order form, or both, provided all automatically. With such an instrument available, providing all rather than those actually required may well be cost effective.[6]

Although the authors have undoubtedly documented an abuse of laboratory testing, it is questionable whether curbing such screening will substantially reduce laboratory costs. The marginal cost of large volume testing on automated equipment, if ordered in batches, is minimal. Indeed, unit costs are heavily volume-dependent and may increase significantly if fewer tests are ordered (the analogy to fares in public transit systems is apt). In my experience, far more expensive abuses include excessive repetition of testing and the ordering of large numbers—often redundant panels—of expensive exotic tests in pursuit of "zebras."

It is noteworthy that house officers (who actually request the tests) are ordering these screening panels in a higher proportion of patients admitted to the authors' medical center than they order urinalyses, despite the apparent greater yield of a urinalysis (I am pleased to note that the authors no longer refer to these as "routine").[1,5] Why are they doing so? Is it possible that their instruction is faulty? Or could it be that, to these young physicians, actions speak louder than words? Could Rucker and co-workers, their role models, be guilty of a "don't do as I do, do as I say" attitude?

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Phosphorus and Water

TO THE EDITOR: In the article "Emergent Management of Chemical Burns," extracted from *Audio-Digest Emergency Medicine,* in the September issue,[1] an erroneous statement regarding the chemical behavior of white phosporus was made. The article states, "White phosphorus is a material that basically ignites when exposed to water." White phosphorus is stored in water because it ignites easily in air.[2] Sodium metal, as the article states, reacts with water and is appropriately stored in oil.

If white phosphorus should come in contact with the skin, washing the area with a 2% solution of copper sulfate has been suggested, although the absorption of copper may be a complication.[3] Rather than covering the wound with oil, as recommended in the extract, the exposed area should be kept thoroughly moist with water until debridement or some other form of treatment can be instituted.

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More Insects in the Operating Room

TO THE EDITOR: A letter to the Editor, "Insects in the Operating Room," by Sherman and co-workers appeared in the September 1987 issue,[1] which arrived several days after the *American Medical News* arrived. The *American Medical News* documented Dr William Burman's interesting approach to dealing with insects in the operating room:[2] he bottled those he detected and sent them to the hospital administrator! Evidently, it was his belief that the insects were permanent residents in the hospital and had not come in with a patient.

Sherman and colleagues describe arresting the trespasser by the "surgical technique known as 'squashing.'" As a family physician I want to make sure that this technique is not entirely expropriated by surgical colleagues. After all it does seem to involve the "whole bug."

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